



# PREScription DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: My Health LAPlan/Medical Group Fax#: 310-669-5609

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request and forward to Department of Health Services Central Pharmacy for processing VIA FAX 310-669-5609 or email [PRIORAUTH@DHS.LACOUNTY.GOV](mailto:PRIORAUTH@DHS.LACOUNTY.GOV).

## Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	MHLA MRN:	Phone#:
Address:		City:	State:	Zip Code:
DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height (in/cm): _____ Weight (lb/kg): _____		Allergies:
Patient's Authorized Representative (if applicable):			Authorized Representative Phone#:	

## Prescriber Information

First Name:	Last Name:		Specialty:		
NPI# (individual):	DEA# (if required):	Phone#: Fax#:		Email:	
MHLA Clinic ID:	Address:	City:	State:	Zip Code:	Preferred Pharmacy Fax/Email:

## Medication Requested

Medication Name:	Dose/Strength:	Frequency:	Quantity:	#Refills:
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal – Date initiated: _____	Duration of Therapy:	Route of Administration: <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____		

## Clinical Information

<b>1. Has the patient tried/failed any other medications for this condition?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
Medication/Therapy failed (Drug and Dosage)	Duration of Therapy (Dates)	Reason for Failure

## 2. Diagnosis

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## 3. Additional Clinical Information – Please provide any other relevant clinical information to support the prior authorization review.

☐ See Attachments

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## 4. Laboratory Tests – Please provide any relevant patient laboratories

WBC      Hgb  
             Hct      Plt

~~TBili~~  
~~AST~~      ~~ALT~~  
~~Alk Phos~~

### Vital Signs

HR:

RR:

BP:

### Other Relevant Laboratories

Na      Cl      BUN  
 K      HCO      Scr      Glu

## 5. Medication Reconciliation – Including Prescription and Over-the-Counter Medications

Medication Name and Dosage	Frequency	Indication	Duration of Therapy	Comments

## 6. Special Considerations

☐Pregnancy  
 ☐Breastfeeding  
 ☐Planning pregnancy  
 ☐Unsure if pregnant  
 ☐Others: \_\_\_\_\_

## 7. Please Indicate Recent Urgent Care/Hospital/Emergency Room Visits – Within last 3 months

Reason/Date	Location	Comments

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Plan Use Only:

☐ Approved  
 ☐ Denied  
 Comments/Information Requested: \_\_\_\_\_